DOCUMENT RESUME

ED 225 090 CG 016 438

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TITLE Family Based Treatment: A Minimally Restrictive Alternative with Special Promise.
PUB DATE Aug 82
NOTE 13p.; Paper presented at the Annual Convention of the American Psychological Association (90th, Washington, DC, August 23-27, 1982).
PUB TYPE Reports - Descriptive (141) -- Speeches/Conference Papers (150)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS *Adolescents; Behavior Change; Change Strategies; *Counseling Techniques; *Family Environment; *Foster Care; *Intervention; Program Descriptions; Residential Programs; *Youth Problems
IDENTIFIERS *Deinstitutionalization (of Delinquents)

ABSTRACT

This paper focuses on two dimensions of interventions for disturbed and disturbing youth, i.e., treatment intensity and restrictiveness. Treatment intensity is presented as a dimension of intervention that includes the factors of: (1) the individualization of the assessment and the treatment plan; (2) the amount of time spent engaging in the activities that are intended to produce behavior change; (3) the amount of "stimulus support" (modeling, instruction, self-instruction, verbal and physical prompting) provided to produce effective, appropriate behavior; (4) the extent to which "motivating operations" are used to assure the effectiveness of reinforcers; (5) the magnitude and scheduling of consequences for effective and ineffective, inappropriate behaviors; and (6) the degree of programming for generalization to the youth's natural environment. The restrictiveness of an intervention is defined in terms of the degree to which available activities deviate from the norm and to which rules limit involvement in such normal activities, the similarity of types and frequency of social contacts to the norm, and the similarity of the physical environment to that encountered by others. The materials describe a program of youth treatment in a family environment to provide highly individualized care. Residential treatment alternatives requiring minimal, moderate, and maximal restrictiveness and treatment intensity are compared. Advantages of the family-based teatment are discussed, including better use of funds, flexibility, incidental learning, and effectiveness as well as risks and limitations of the program. (JAC)

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FAMILY BASED TREATMENT:
A Minimally Restrictive Alternative With Special Promise

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CG 016438

Paper presented at the Annual Conference of the American Psychological Association, Washington, DC, August 23-27, 1982.

Family Based Treatment:
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Interventions for disturbed and disturbing youth have varied on many dimensions. We would like to focus here on two of those dimensions: treatment intensity and restrictiveness.

The treatment intensity of an intervention includes such factors as these: (1) the individualization of the assessment and the treatment plan; (2) the amount of time spent engaging in the activities that are intended to produce behavior (or other) change; (3) the amount of "stimulus support" (modeling, instruction, self-instruction, verbal and physical prompting, etc.) provided to produce effective, appropriate behavior; (4) the extent of which "motivating operations" are used to assure the effectiveness of reinforcers; (5) the magnitude and scheduling of consequences for the effective and ineffective, inappropriate behaviors; and (6) the degree of programming for generalization to the youth's natural environment.

The restrictiveness of an intervention includes such factors as these: (1) the degree to which available activities deviate from the norm (for persons of comparable age or development); (2) the degree to which rules limit involvement in such normal activities; (3) the similarity of types and frequency of social contacts to the norm; and (4) the similarity of the physical environment to that encountered by others.

Typically, minor problems of youth are dealt with in the least restrictive and least intense manner. A parent or teacher may take the youth aside and talk with him or her about the problem, or the parent may institute some new contingency

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Paper presented in E. L. Phillips'(Chairperson), Behavioral treatment of youth in professional foster homes. Symposium presented at the American Psychological Association convention, Washington, D.C., August, 1982.

such as prompting the youth to do certain things at the appropriate time. More debilitating or disruptive problems are likely to be dealt with at a more treatment-intensive and more restrictive level: the youth may be placed in a special school program or specialized foster home. Problems that are severely debilitating for the youngster or intolerable to others are treated at the most restrictive level, though often not the most treatment-intensive: the youth may be placed in an institution and, if fortunate, may have most of his or her day occupied by activities designed carefully to produce favorable behavior change.

Though treatment intensity and restrictiveness often go together, this is not always the case. When parents are taught to provide intensive training for their child at home, the restrictiveness of their intervention may be minimal, but the treatment intensity may be quite substantial. And many institution programs are highly restrictive, yet minimally treatment-intensive, with numerous limitations and restrictions but little training in constructive, effective, prosocial behavior.

Examples of interventions are given in Figure 1 to illustrate roughly how they might rank on the two dimensions.

The costs of an intervention -- in terms of dollars, time, effort, or other resources -- usually increase with an increase in either treatment intensity or restrictiveness. The treatment intensity of interventions tends to correlate with the degree to which the youth's problems are debilitating and discomforting to <u>himself</u>; while the restrictiveness may be more correlated with the discomfort that the problem causes for <u>others</u>.

In keeping with Pressley Ridge School's general ecological approach in treating troubled and troubling youth (Hobbs, 1982), we began in 1980 considering whether we could devise a program that was less restrictive than our wilderness school program, our cottage program, and perhaps even our special day school program, yet just as treatment-intensive as any of them. What we arrived at was a program with the following characteristics: it would treat the youth in a normal family environment; it would be highly individualized to the youth's unique problems; it would have 24-hour impact on virtually all activities and situations that the youth might enter, including his school and natural home environment; and it would involve in-depth, skilled programming for behavior

TREATMENT INTENSITY	MINIMAL	MODERATE	MAXIMAL
MAXIMAL	Family-based treatment	Systematically, structured group home (e.g., Teaching Family model)	Systematic institution with generalization programmed (e.g., Brainerd State Hospital in Minn.)
MODERATE	Specialized foster care Outpatient social skills training Individualized training of natural parents in clinic setting.	Special classroom most of school day Good group home	Psychiatric hospitaliza- with in-hospital intensive skill training
MINIMAL	Foster care Typical group training of parents of troubled children Typical, once-a-week counseling	Minimally skilled and supervised group home Special classroom for only a few hours per week in school (e.g., resource room)	Typical state hospital Typical "correctional" institution

RESTRICTIVENESS

change. This program would be one in which we recruited promising couples from the community, trained them in several important methods of behavior change, gave them a youth who needed treatment and then further trained and supervised them while they carried out a daily individualized treatment plan. Meanwhile, we would work with the youth's natural parents or guardians (if there was much likelihood that the youth would return to that home) to make their home more conductive in a good adjustment when the youth returns there. Finally, we would pay these couples enough to reasonably compensate them for professional quality work.

We found that our idea was not totally new. Within social work a somewhat similar model had developed that was called "specialized foster care," a form of foster care that serves handicapped and troubled youth. Specialized foster care began as early as 1951, spread somewhat in the 1960s, and then spread rapidly in the 1970s (Bryant, 1980), until it is now a familiar concept in social work.

Specialized Foster Care

Specialized foster care is more treatment oriented than regular foster care, in several ways: (1) specialized foster parents are probably more carefully selected; (2) they are typically given some education or training on at least a preservice basis, and often on an inservice basis as well; (3) they are given more supervision and assistance; and (4) they are paid more.

We studied or visited several such programs and found that "Because of its basic similarity to traditional foster care, specialized foster care is generally viewed as a 'variation on a theme'"(Barnes, 1980, p.6). That is, it was a moderate improvement over regular foster care, from which it developed. Perhaps because of this origin in regular foster care, specialized foster care was not the kind of program we had in mind. First, the assumptions about the possible roles of the foster parents were unlike ours: they are seen as providing food, shelter, emotional support, advice, assistance, and structure. Barnes (1980) in describing specialized foster care for "hard to place" juvenile offenders, presented an accurate picture of the role of the specialized foster parent when she said that "It is neither expected nor appropriate for a foster parent to provide in-depth counseling or therapy for youth placed in their care" (p.6).

In contrast, our plan was that the foster parents would be the primary treatment agents, providing virtually continuous treatment throughout every day, through re-education of the child. Second, the assumptions about parent training were unlike ours: it was viewed as educating the foster parents about the agency, the youth, the referral and placement process, possible ways to deal with problems, and so on (of Barnes, 1980). Our own plan was to train parents to do particular things that would effectively change the youth's behavior. Third, the assumptions about supervision of couples were unlike ours: supervision was seen as guidance and support, rather than continued training and motivation. Fourth, the assumptions about renumeration were unlike ours: payments to couples in many of the programs would be inadequate to get the level of treatment activity and accountability that we considered necessary. And fifth, the concept of what constitutes an effective, accountable program was unlike ours: specialized foster care programs all appeared to be eclectic, used much trial-and-error, and collected few if any data by which the program or the parents could be evaluated. Our plan was to develop a program with a clear commitment to a particular treatment approach, and with built-in accountability of several kinds.

Our assumptions had grown out of intensive work with troubled youngsters in clinics, school program, cottage programs, our wilderness school, and in various other contexts. The specialized foster care had grown out of a history of regular foster care. We decided that the differences between specialized foster care and the program we wished to develop were too great to give them the same name. Thus we called our plan "family-based treatment."

Advantages of Family-Based Treatment

We have found several substantial advantages to family-based treatment that should be considered by any agency interested in developing programs for troubled or troubling youth.

Minimally Restrictive

As indicated above, family-based treatment can substitute for institutional or group home placement for many children with many types of problems. This avoids the ill effects that sometimes occur in such group placements: peer modeling and reinforcement of ineffective or destructive behavior; development of dependent, helpless behaviors; failure to develop normal community living skills; and even neglect or abuse by poorly supervised staff, who often work

on a shift basis and resign in a year or less. Further, a less restrictive environment is a more human, enjoyable place for most youth.

Better Use of Funds

Of particular importance during this time of scarce dollars is the cost of treatment. Since treatment physically takes place in the homes and schools of the community, there is little major outlay of capital for land, buildings, or equipment. There is no need for food or laundry services, and building maintenance is limited to a small central office. The result is that family-based treatment is less expensive than most institutional or even group home programs. But perhaps more important than total cost is the fact that funds are substantially redirected. Compared to institutional programs, a much larger percentage of funds are allocated to costs that are directly related to treatment: assessment of youngsters and their environments, training and supervision of the direct-treatment "staff" (parents), work with natural parents, work with schools and other community resources, and direct work with youngsters.

Flexibility to Adjust Service to Demand

A family-based program can expand or contract as local needs change. As the demand for service increases, the recruitment and training of parents is intensified. If referrals or funding reduce, program contraction is relatively easy. The traditional institutional concerns are minimized regarding unfilled beds, unoccupied offices, unused clerical and maintenance staff and such.

Continuous, Relevant, Individualized Assessment and Treatment

Because the youth is living in the very kind of environment in which he or she has had difficulty, detailed observations of everyday behavior are not only possible but inevitable. The behavior excesses and deficits are evidenced because the opportunities for them are frequent. They can be pinpointed and interventions planned.

Similarly, the intervention can be implemented directly in the kind of environment where behavior change is needed. Instead of "training and hoping" or even carrying out complex procedures to obtain generalization of behavior

changes from the treatment environment to the natural environment, one can conduct much of the treatment in the natural enviroment itself (cf Stokes & Baer, 1977). Further, virtually any problem can be addressed, because one has access to the settings where it exists. Finally, any intervention is likely to be more effective when the parties involved know that they will be living together all day, every day of the week, every week of the year for an indefinite period, so that each will have to live with the interpersonal consequences of his or her actions for a long time, and family-based treatment can provide this kind of long-term involvement better than any program involving shift work or frequent staff turnover.

Broad Range of Clients

Though our residential cottage program was a well-versed and respected setting for treatment of a variety of troubled and troubling youngsters, there are limits to the range of youth one can mix together. Sex, age, type of problem, intellectual skill level, physical handicaps, and other variables influenced who we could accept at any point in time. For example, a seventeen year old blind girl with very disturbing behavior would have been wholly inappropriate for the cottage program, due to limitations of the physical facility of the peer group, of staff expertise, and other factors. Yet our family-based program readily provided a highly individualized and totally appropriate treatment program for this youngster. Among our first 15 youth were a seven year old firghtened girl; a thirteen year old deaf, disturbing boy; a fourteen year old, 180 lb., dangerously aggressive boy, and the above blind girl.

Prof readily Important Incidental Learning

A youth living with a well-adjusted, responsible, caring couple learns numerous valuable skills and bits of information quite incidentally. First, he or she learns the everyday skills and responsibilities involved in getting and maintaining a home: talking to salespeople, making contracts, intelligent food selection, home repair, cooking, and such. Second, he or she learns at least a few things about work: finding jobs that one is prepared for, getting to work on time, pleasing a boss, and such. Third, he or she learns many things about recreation: planning a trip, packing, rowing a boat, joining a ball team and so on. Fourth, he or she learns many things about social relations in and out of family life: taking responsibility for others, getting along with neighbors,

getting help from clerks, showing affection and appreciation, having friends for dinner, and numerous others. In the long run, some of these skills and information may be the most important benefits received by a particular youth.

Risks and Limitations

Within the past year, our family-based treatment program has surpassed the expectations of those of us who developed the model. We have been surprised by the diversity and severity of problems which can be successfully addressed within the model. We have been impressed by the quality of parents we get. And we have been pleased with the small percentage of parents who give up and quit, with the small percentage of youth who give up and run away, and with the energy, enthusiasm, resourcefulness and persistence of the parent-supervisory staff.

But we are quite aware that the model has limitations. First, the parent supervisors have a remarkably demanding job. They play a very wide range of roles, often including psychological assessor, treatment planner and coordinator, therapist to the child, child advocate in court, enforcer of regulations, preservice trainer, inservice trainer, parent counselor, parent recruiter, program evaluator, and peer supporter. Their work schedules are erratic, because they must be on call 24 hours a day and often must be in a home in the evening to train parents and monitor progress. As a result, their job description ends with a statement to the effect that they will be expected to "do anything else which needs to be done," which includes taking a highly disruptive youngster into their own home.[1] Obviously, one must be able to recruit unusually resourceful, energetic, committed people who can work together well with each other and with parents of widely varying background and temperament.

A second limitation is that the role of being a professional "treatment parent" requires very adaptable, persistent, resourceful people. Their role is not technically as staff members, yet we expect them to undergo training both before they receive a youth and for a long time afterward; we expect a professional kind of commitment to the youth's progress; and we expect them to follow our treatment procedures faithfully, keep daily records, attend progress evaluations, and such.

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[1] In fact, every member of the staff, including the Director and the part-time consultant, has served as a parent for at least one of our youth.

A third limitation is that the travel requirement for parent supervisors is enormous. In order to provide adequate supervision and to monitor implementation of treatment plans, they must be physically present in treatment homes as needed, usually weekly. In addition, they often must go to a youth's natural home, to juvenile court, to a school, to the child welfare office, to institutions, to the juvenile detention center, and to various other places if they are to perform their jobs effectively.

Fourth, it can take substantial effort to educate personnel in traditional child-serving systems about the differences between family-based treatment and other child care or treatment services, particularly regular foster care and specialized foster care. Since the youth is living with foster parents, the arrangement is initially viewed as foster care, even if the program is serving very difficult youth very effectively.[2]

Finally, we want to make it clear that the processes of selecting parents, training and supervising parents, and matching a youth with parents are based largely on educated guesswork. One must make predictions about who will make a good treatment parent for what kind of youth. One must see that their expectations about the work are realistic and that they have sufficient skill to deal with a variety of problems effectively. Yet the data base for many of these decisions is minimal, and one must be prepared for errors. The need for research is obvious.

Conclusion

Our commitment to the utilization of paraprofessionals, to the improvement of children's ecologies, to minimizing the institutionalization of youth, to accountability within programs and beyond, and to utilizing effective, empirically-based technologies have all led us to the development of this family-based model of treatment. During the past 1½ years of implemenation, our expectations for success have been confirmed. We believe we, along with others, are involved in the development of a new more humane, more cost effective, less restrictive form of treatment for troubled and troubling youth.

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[2]This problem is exacerbated by the fact that child-serving systems rarely have methods for quantifying either the difficulty of a case or the effectiveness of treatment, which tends to result in one placement being viewed as the equivalent of another and economy (in the short run) becoming paramount.

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